Improvement Fund - End of Project Report

We have designed this form to be flexible so that you can evaluate your project in a way that is meaningful to you but that covers our needs as a Funder too. We have provided prompts for the information we are looking for. Please cover all the points that are applicable to you.

Please note that this form will be published on our website and identify the organisations involved in the project.

Please contact hcis.improvementfund@nhs.net if you have any questions.

Project Details	
Project Title	Integrating Money Advice within Primary Care
Date of Report	August 2018
Project Start Date	27th March 2017
Project End Date	27th June 2018
Lead Organisation	Glasgow City Health and Social Care Partnership (North East Locality)
Partner Organisation(s)	GEMAP Scotland Ltd Glasgow Centre for Population Health Deep End

What we expected to do

Please cover the following information. (You can use information from your application form to complete this section). Guideline word count: 500 words.

A summary of what you said you'd do including:

- *What was the need or problem that this project will address?*
- *What did you want to achieve with this funding? What were your aims and measures to demonstrate if your work has been successful in achieving what you set out to do?*

The main activities or services you planned to provide to deliver your aims.
[this section could also include a reminder of the overall aim of the organisation or project to set the context]

Patients living in North East Glasgow are disproportionately affected by poverty. This has an impact on GP practices in their delivery of services. We planned to support each GP practice within the Parkhead cluster area to address poverty by funding the embedding of a Money Advice worker in each GP practice a half day a week. The worker would take referrals directly from the practice team supporting the aspiration that practices will function with wider multi disciplinary support.

Outcomes expected to include income maximisation, mitigating welfare reform changes, supporting debt management and financial capability.

We were hopeful that at the end of the funding period we would have a service that would support GP practices to directly refer patients to access money advice. This would allow us to consider our mainstream funding and the potential re configuration of services. At the very least, if sustained funding was unavailable, we would expect to have a robust referral system that practices could utilise. Despite the existence of universal money advice referral pathway for several years, our data demonstrated that GPs seldom used this even although evidence suggests that they do recognise the importance of their patients accessing quality advice.

Whilst we had already piloted embedding an advice worker in two GP practices in Parkhead

Health Centre, and preliminary findings were very positive, this funding allowed us to scale up the model and build on the learning achieved to date.

The new model of GP clusters provides this opportunity. Our aim was to provide each practice with a dedicated advisor half a day a week. The majority of GP practice patients access their GP at least once a year. By embedding advice and supporting practice ownership this can make a significant difference to referrals and the reach of advice services. Combined, these practices had a list size just under 35,000 people.
Whilst there will always be practitioners who do not view referral to advice agencies as part of a treatment option, we anticipated that evidence of the effectiveness of this work, coupled with peer influences, would persuade colleagues to adopt the model.

What we actually did

Guideline word count: 500 words.
Please cover the following information:

- *Description of the intervention(s), or changes that were implemented in sufficient detail that others could reproduce it.*

  GP Practice Health Professional, in conversation with patient, identifies the need for a money advice referral and seeks patient's permission to refer to our provider (GEMAP), this is recorded in patient's case notes. A referral form is completed and emailed via secure system (NHS.net) to GEMAP. Patient is contacted by GEMAP, their concern triaged and appointment arranged as required, Practice notified of appointment and patient seen in GP practice. Money Advice Worker undertakes assessment, intervention, supports benefit application, income maximisation, debt advice, rescheduling etc as required. Patient is seen for follow up as required. Onward referrals to other services as appropriate and outcomes recorded on provider's system. Practice aware of intervention and copies of appeal letters etc filed in patient's electronic notes.

- *What framework or structure was in place to test out the change and monitor and understand progress? (E.g. meetings to reflect on progress, analysis of data etc.) If you have used any specific tools or methods/ approaches, please outline these.*

  We have a clear reporting template with our advice provider GEMAP who use Advice Pro in their data collection. The information and reporting template has been agreed, refined and developed over a number of years to ensure data capture and reporting is robust and meets our needs. Equalities monitoring data is included. We have also captured additional data on onward referrals to wider support services to evidence the holistic nature of the intervention. Data is presented on a more regular basis to Practices via cluster meetings to demonstrate performance (e.g. number and nature of referrals).

- *Specifics of the team involved in the work and their roles in implementation.*
- *How you worked in partnership to deliver your project.*

- The strategic partnerships are described in the section below around what difference we actually made. *However* in terms of partnership, operationally the project was delivered by key Health Improvement staff, including a Health Improvement Senior with direct links to each Practice, GEMAP's Chief Executive, front line Advisors and key Practice staff.
- Our Health Improvement Senior allocated around 50% of their time to

operationalising the project and was the key lynch pin in its success acting as a development worker solving issues, identifying barriers, reporting and ensuring good communications at all levels. The Health Improvement Financial Inclusion team met initially on a weekly basis with GEMAP staff and had a clear project plan to implement; the frequency of these meetings decreased to monthly as the project developed.

- *The main facts and figures about actual activities carried out, for example the number of people worked with and the main things they did.*
- GEMAP's end of project report Appendix 1

What difference we actually made

Guideline word count: 700 words. Please attach any additional supporting information as an appendix. See Appendix 1
Please cover the following information:

- *Key findings from any formal evaluation (where possible please attach a graph or table to evidence the improvement made)*
- *Details of what difference was made (quantitative and/or qualitative results).*

- In terms of key findings GEMAPS full end of project results are included as appendix 1, however key highlights include the following:
- The overall number of recorded referrals were 665 of which 576 (86.6%) were from GPs.
- Referral data on 654 people showed that 451 (68.9%) engaged with advice services.
- 124 people received onward referrals to other agencies/services with homeless and housing issues accounting for over a third (n=64) and more than one in10 accessing mental health support. There was around £1.5 million in gains with disability-related benefits accounting for over half of the gains. Debt management totalled more than £470,000.
- At a household level, the average gain was £8,253 or a median figure of £1,453 with negotiated debts averaging £4,356 or a median of £1,993.
- *Reasons for any differences between observed and anticipated outcomes, including the influence of contextual factors.*
- The outcomes were as expected. If anything it was possibly easier than expected to roll out the project due to an established track record of supporting advice delivery in other healthcare settings, existence of the GP cluster group and agreement that this was a cluster priority. In reality, some Practices were (and remain) less engaged than others. We have explored and tried to address this once barriers or issues were identified. There are a number of these including the variation in operational processes within (and between) each Practice, the availability of Practice Mangers and GPs due to workload demands, inconsistent dissemination of information amongst Practice staff and general communications challenges. *Who benefitted from the project and do they think any individuals/groups were unintentionally excluded for any reason?*

- *Particular strengths/ weaknesses of the project.*
- The data shows that working age adults made up the bulk of the client group.
- Amongst a surveyed sample of 326 people, 65.7% stated that they had not accessed the advice agency before, which suggests a potentially high level of unmet need..
- The majority who were referred to and engaged with the service were recorded as white Scottish.

- The largest group in terms of referrals were unfit for work.
- The majority of people referred (65%) had an income of less than £10,000. With 5% reporting an income of over £25,000. Lone parents accounted for 16.5% of clients.
- *Could also include examples of how individual participants or service users experienced the projects (such as case studies or quotes).*

GCPH evaluation which is not yet available has included telephone interviews with people who had received an onward referral to other services to look at uptake and outcomes. Further interviews with GPs and Practice staff were undertaken with eight out of nine practices participating in the interview process.

- *How did partnership working contribute to the success of your project*

The project retained the existing Advisory Group which was established for the original two GP practices, members included key strategic partners (e.g. Glasgow University Deep End, Glasgow Centre for Population Health) as well as key GPs and the Health Improvement team. We also invited our local regeneration agency (Clyde Gateway) to participate which increased their understanding of the approach and ultimately convinced them to fund service delivery during 2018/19; the project also benefits from Clyde Gateway's influence at a city and national level. The advisory group lends a high degree of credibility and prestige to conversations with colleagues and other GPs in terms of supporting the work.
The partnership working continues with attendance and reporting at the local GP cluster group where the project is one of their key improvement activities. The Cluster Lead reports this via the NE Primary Care Implementation group.

- *Next steps.*

The project has secured an additional years funding from Clyde Gateway to continue to build on the learning and explore the development of employability supports for patients engaging with the project, if applicable. Reports will be disseminated and shared. The project has provided the opportunity to potentially influence the Primary Care services in relation to multi disciplinary considerations.

Challenges and how/if they were overcome

Guideline word count: 200 words.
Please cover the following information:

- *Any problems you encountered along the way that slowed progress stopped the outcomes happening and whether changes or solutions were implemented as a result.*

One of the challenges was in receiving referrals from a couple of Practices. This has taken longer than anticipated despite buy-in from the Practices, often key personnel are unavailable, off sick, too busy and locums covering absences during summer months who may not be familiar with the programme. To overcome some of these challenges, regular visits were made to practices and information was included in locum packs. In addition, our Health Improvement Senior would shadow the money advice worker and this allowed positive relationships to develop to help overcome any glitches experienced by GEMAP. With the continued funding, this will allow us to see if these strategies overcome slow referreral rates or if more radical action is required (e.g. removal of service).

Learning for the future

Guideline word count: 600 words.
Please cover the following information:

- *Key learning points.*

- If implementing this model with GP Practices in future, it would be prudent to develop a Service Level Agreement which is signed by the Lead GP within each Practice detailing what to expect from the service and the requirements of the practice. In particular, the agreement would specify the key systems and processes which must be in place at the start of the project, and on an ongoing basis, to ensure successful outcomes.
- After Practices have established the service, ringfenced time should be allocated to meet the operational lead to review, improve and respond to any emerging issues. This process provides a degree of governance to ensure a consistent, quality assured service is offered to all patients in each of the participating Practices. Whilst Practices are very busy and thus naturally inclined to approach advisors directly on site to affect service changes, it must be recognised that advisors do not necessarily have an understanding of the implications of proposed service changes and thus these must be ratified by management.
- As each practice is unique, it may be the Practice Manager or a GP (or other) who provides the key link with the project and it is crucial to agree this as early as possible to avoid communication problems.
- Remember to ensure reception staff understands what the project is about and that they are key allies in promoting the service to patients.
- Feedback on progress and outcomes to the Practice team is vital to reinforce the value of the project and to sustain momentum. Feedback should be easy to understand and assimilate quickly; infographics with key messages are well received by staff. At a cluster level, 'league table' style performance data by Practice has been welcomed.
- Confidentiality and access to patient records can trigger anxieties to Practices and this has been exacerbated with the implementation of GDPR in May 2018.

- *Unexpected outcomes (positive or negative).*

- A positive unexpected outcome has been that the profile and credibility of Health Improvement has increased significantly and this has supported other areas of work which we would want to implement / progress. The work is reported via the Parkhead local Cluster meetings and this has supported other Health Improvement initiatives to be developed and trialled. For example, our Smoking Cessation team has successfully developed much closer relationships with Practices, resulting in increased referrals, and the embedding of a physical activity advisor has been piloted in one Practice (evaluation underway.) Finally, the strengthening of trusting relationships has supported the facilitation of pop up cervical screening clinics targeting vulnerable frequent non attendees. All of these initiatives have been relatively straightforward to implement given the credibility Health Improvement has now established with Practices.
- This credibility transfers to the wider Primary Care Implementation group, where the work is reported, which has representation from all North East GP clusters. This allows us to generate support for other topics, an innovative example is Practices sending letters in the New Year to patients who smoke inviting them to sign up for cessation classes, and setting up outreaches in other sites.

- *Anything they will do differently in the future.*

As above

- *Advice for others with similar projects.*

- Good buy-in from at least one key individual within the practice is paramount.
- Signed service level agreement outlining the expectations of all partners.
- Ensure the patient mandate includes consent to participate in the follow-up service evaluation at the outset (thus preventing the need to seek retrospective consent).
- Align a key operational lead with ring fenced time to implement and operationalise the project to the standard that is expected and agreed.
- Ensure funding is in place to sustain the work. Once GPs have a service in place which they value, discontinuation of funding presents challenges. The model is tested and proven, it just needs to be resourced appropriately and it will generate the desired outcomes. Practices could consider funding themselves or lobby for funding via their Primary Care allocations.

- *Your plan for sustaining the project post funding*
- *Suggestions for suitability and limitations for potential spread to other contexts.*
- *Next steps, e.g. plans for spreading to the next level.*

Securing long term funding remains challenging; currently we are operating on a year to year basis, in the context of expected budget savings. We have been actively raising the profile of this programme at a range of levels, locally, at a city level and nationally in the hope of securing additional funds. Nationally, there is some traction via NHS Health Scotland and the Scottish Public Health Network (ScotPHN) who has a key work stream around the impact of Welfare Reform. As part of Scottish Government plans to fund additional Community Links Workers, a draft briefing paper has been developed for HSCPs to consider the recruitment of a small number of Specialist Links Workers (Money Advice) in General Practice via funding aligned to their Primary Care plans.

The publication of Citizens Advice and RCGP research on integrating money advice in General Practice research has been widely shared at a city and NHS Board levelhttps://www.citizensadvice.org.uk/Global/Public/Impact/Understanding%20the%20effects%20of%20advice%20in%20primary%20care%20settings_research%20report%20(final).pdf

We are looking at the project to identify which positive aspects we can retain, in the event that funding is discontinued. At the very least, we will have improved GP understanding of a vital advice service during a period of increased demand via welfare reform and an electronic referral pathway that GPs can continue to use, albeit Practices would no longer have an embedded advisor with access to patient notes.

Summary of how learning from the project has already been shared so far

In addition to our project Advisory Group and local forums, we have presented at the Glasgow City Primary Care Group, as the GG&C NHS Financial Inclusion Group and Glasgow City Council Network of advice providers. We further have met with colleagues from Scottish Government and with colleagues leading on this within Health Scotland.

- *Plan for how learning from the project will be actively shared going forward. E.g. through events, presentations, publications etc. Please be specific.*

When GCPHs report is available it will be disseminated widely posted on their website publicised via social media and possibly an event to share the findings, this has still to be confirmed.

Other
Please cover the following information: • *Budget details (this can be presented in a table or as text)* Excel spreadsheet with spend detail outlined. APPENDIX 2 • *Anything else you would like to mention that doesn't fit in the other sections.* Thank you for funding opportunity

This report template has been adapted from the Report to the Scotland Funders' Forum Link and the Revised Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0) publication guidelines.